Authorized Representative

This form allows a 22 Health Member to choose a Personal Representative to act on their behalf. This form must be filled out by the Member.If the Member cannot complete this form, his or her legal representative may fill it out. Documentation must be provided supporting the legal authority to act on the Member's behalf (e.g., Power of Attorney, Letters of Guardianship, Designation of Health Care Surrogate).

Please return this completed Authorized Representative Form to Member Services by email, fax or mail to:

22 Health
1643 Harrison Parkway, Suite H-200
Sunrise, Florida 33323
Fax: (954) 251-4607

Email: Support@22healthplan.com

Note: Email may not be secure. Do not include sensitive information unless you accept this risk.

Member Services will update your account and notify all relevant departments, including Grievances & Appeals, Enrollment, and Compliance, if necessary, of your authorized representative.

MEMBER INFORMATION

Name _____

Member ID # _____ **Date of Birth** ____/____/____

I authorize the following person to be my Personal Representative:

Printed Name _____

Relationship to Member _____

Telephone _____

Address _____

Email _____

I AUTHORIZE THIS PERSON TO ACCESS ALL OF THESE ON MY BEHALF:

☐ Claims ☐ Eligibility/Billing information ☐ Medical Records

☐ Submit a complaint or request an appeal or grievance for the event-specific matter below.

☐ Discuss all of my Protected Health Information (PHI) and my health care (all of the above).

☐ Authorize the sharing and disclosure of PHI with third parties for authorized purposes.

If Event-specific (e.g. one appeal/grievance), describe the matter/service here:

_____

_____

22 Health
A Division of Community Care Plan

Authorized Representative

INFORMATION CATEGORIES AND DISCLOSURES

The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to eligibility and billing, claims, chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually transmitted diseases, HIV/AIDS, and/or genetic marker information.

EXPIRATION, COMMUNICATIONS, AND REVOCATION

- [ ] This authorization expires in one (1) year after the date signed below.
- [ ] Authorize the sharing and disclosure of PHI with third parties for authorized purposes.

SEND CORRESPONDENCE ABOUT THE MATTER TO:

- [ ] Member only
- [ ] Personal Representative
- [ ] Both

REVOCATION NOTICE

I understand that I may revoke this authorization at any time by notifying 22 Health in writing, except to the extent action has already been taken.

Signature _____

Date _____/_____/_____

Print Name _____

If person signing this Authorization is not the Member, describe relationship to the Member (i.e. Parent, Legal Representative[1].

_____

_____

[1] Legal Representatives signing this authorization on behalf of a Member must furnish a copy of a Power of Attorney, Letters of Guardianship, Designation of Health Care Surrogate, or other relevant document that grants the applicable legal authority.